INITIAL HISTORY AND EXAM

Date_____ Name_____

Maiden Name_____

DOB_____ Age_____ Patner/Husband Name_____

Married to Mother? _____ Husband DOB_____Age_____

Address Residence_____

Address Mailing_____

Home Phone_____ Cell phone_____

Emergency Contact information_____

FAMILY HEALTH HISTORY

	Mother	Father	Siblings	Grandparents	Father's Family
Cancer					
High Blood Pressure					
Heart Disease					
Diabetes					
Tuberculosis					
Epilepsy					
Alcoholism					
Birth Defects					
Twins					
C-Sections					

Other additional information or details

_____

_____

YOUR MEDICAL HISTORY

Asthma_____
Cancer_____
Severe Headaches_____
Vision Problems_____
Hearing Problems_____
Dental Problems_____
Thyroid Problems_____
Rheumatic Fever_____
Blood Clotting_____
High Blood Pressure_____
Low Blood Pressure_____
Varicose Veins_____
Hemorrhoids_____
Stomach Problems_____
Liver Disease_____
Gall Bladder Disease_____
Chronic Constipation_____
Chronic Diarrhea_____

Diabetes_____
Low Blood Sugar_____
Seizures_____
Pelvic/Back injury_____
Aching Joints/Arthritis_____
Broken Bones_____
Bladder Infections_____
Kidney Infections/Disease_____
Blood Clots_____
Pelvic infections_____
Immune Disorders_____
Blood Transfusions_____
Depression/Psychological Disorders_____
Drug/Alcohol Problems_____

Details_____

_____

Describe any injuries, traumas, hospitalizations or surgeries with dates included:

_____

_____

_____

Allergies to Medications_____ Foods_____ Other_____

Did you have chicken pox as a kid? _____ When? _____

Immunizations: (Circle those you received)

DPT Polio Mumps Rubella Measles Tetanus Heb B

YOUR GYNECOLOGICAL HISTORY

Age at first period_____ Length of cycle before this pregnancy_____

Regular_____

How many days do you bleed? _____ Circle Flow light medium heavy

Do you pass clots or have excessive cramping? _____

What age did you become sexually active? _____

Ever been sexually abused? _____Did you receive counseling? _____

Date of Last Pap? _____Normal?_____Ever Abnormal?_____

Do you think you are at an increased risk for HIV/Aids?_____

Please circle if you have a history with:

Yeast HPV Trich. Bact. Vaginosis Herpes Chlamydia Gonorrhea Syphillis

Genital Sores PID Cervicitis Fibroids Ovarian Cyst Endometriosis Infertility

Uterine/Cervical Surgery Breast lumps/biopsy/surgery

Details_____

_____

What kinds of birth control have you used?

Type Kind Age How long Problems

Pill:_____

IUD:_____

Norplant:_____

DepoProvera:_____

Diaphragm/Cervicalcap:_____

Condoms:_____

Other:_____

Have you ever been treated for any unusual gynecological problems?

_____

_____

YOUR MOTHER'S GYNECOLOGICAL HISTORY

of pregnancies_____ # of live births_____

# of miscarriages_____

Did she take DES?_____ Complications with pregnancy?_____

Complications with births?_____

What #were you? (1st, 2nd etc…)_____ Your birth weight?_____Partner's birth weight_____How would you describe her attitude towards birth in general?_____Homebirth?_____Breastfeeding?_____

YOUR PREGNANCY HISTORY

How many times have you been pregnant?_____How many births?_____

Premature Births?_____Stillbirths?_____Cause?_____

How many children still living?_____Miscarriages?_____

Weeks pregnant?_____ Approximate Dates:_____

Abortions?_____Approximate Dates:_____

PREVIOUS PREGNANCIES/BIRTHS

Child's name					
Date of Birth					
Pregnancy Complications					
Location of Birth					
Length of Labor					
Length of Pushing					
Any Medications					
Type of Delivery					
Complications with Mom					
Birth weight					
Complications with baby					
Breastfed					
How long					
Other					
Other					

YOUR PRESENT PREGNANCY

1ST Day of last menstrual Period (LMP)_____ Normal?_____
Conception Date_____
Pregnancy Test?_____ Date_____
Is this a planned Pregnancy?_____
How do you feel about being pregnant?_____
How does your partner feel?_____
Have you felt the baby move?_____Date first felt?_____
How would you describe your pregnancy so far?_____

During this pregnancy have you used or been exposed to:

Tobacco_____
Alcohol_____
Caffeine_____
Recreational Drugs_____
Prescription Drugs_____
Vitamins_____
Herbs_____
Chemicals_____

X-rays_____
Ultrasound_____
Measles_____
Viruses_____
Vaccines_____
Cats_____
Raw Meat_____

Have you experienced any of the following during this pregnancy? (Circle all those that apply) Nausea Vomiting Fever Headaches Dizziness Indigestion Leg Cramps Rash Backache Swelling Constipation Diarrhea Urinary Complications Abdominal/Pelvic Pain
Vaginal Bleeding/Spotting Vaginal Discharge Bleeding Gums Varicose Veins Hemorrhoids Loneliness Depression Family Problems Work Problems
Other_____

Do you have any dietary restrictions? Please explain_____
How would you describe your overall health condition?_____
Are there any specific ethnic, cultural, religious, or personal preferences you would like to discuss concerning your care?_____
_____
Are you planning on breastfeeding this baby?_____
For how long?_____

BASELINE PHYSICAL EXAM

Date_____ Weeks Pregnant_____LMP_____EDD_____G____P____

Height_____Weight_____PP Weight_____BP_____Pulse_____Temp____Resp_____

Physical Observations:

HEENT:_____

TEETH/GUMS_____

THYROID_____

LYMPH_____

NODES_____

SKIN_____

HEART_____

LUNGS_____

BACK_____

BREASTS_____

NIPPLES_____

INSTRUCTIONS IN SELF EXAM_____

ABDOMIN_____

PAIN/TENDERNESS_____

LIVER_____

FUNDAL HEIGHT_____

SCARS_____

STRETCH MARKS_____

MUSCLE TONE_____

FETAL HEART TONES Strong Regular

Faint Undetected

HEARD WITH Fetoscope Doppler

POSITION OF

BABY_____

LEGS_____

SWELLING_____

VARICOSITIES_____

PELVIC EXAM DONE TODAY_____

EXTERNAL GENITALIA_____

SCARRING_____

LESIONS_____

VARICOSITIES_____

HEMORROIDS_____

VAGINA_____

COLOR_____TONE_____

ADNEXA_____OVARIES_____

CERVIX_____LOCATION_____

LENGTH_____CONTOUR____

DILATION_____

DIAGONAL CONJUGATE_____

COCCYX_____

SHAPE/SACRUM_____

ISCHIAL SPINES_____

DEFERRED UNTIL_____

BI-ISCHIALDIAMETER_____

ARCHANGLE_____

WIDTH_____

UTERUS_____

BI-TUBEROUS DIAMETER_____

RECTUM_____

CLASSIFICATION:

__GYNECOID

___ANDROID

___ANTHROPOID

___PLATYPELLOID

ASSESSMENT:

Adequate Borderline Contracted

LARGEST BABY DELIVERED_____

PTS REACTION_____

Unusual Findings_____

Recommendations_____

Re-Assessment_____

RISK ASSESSMENT

Appropriate for Midwifery Care_____ Risk Level: Low Moderate High

Consult needed for_____

Outstanding issues for resolution_____